INFORMATION FOR APPLICANTS ABOUT MEDICAID AND FAMIS-PLUS

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Mission Statement: *To provide a system of high quality comprehensive health services to qualifying Virginians and their families.*

Effective
December 2004

www.dmas.virginia.gov

GENERAL INFORMATION REGARDING MEDICAID AND FAMIS PLUS

Medicaid and its coverage for children under FAMIS Plus are assistance programs that help pay for medical care. To be eligible for Medicaid or FAMIS Plus you must have limited income and resources and you must be in one of the groups of people covered by Medicaid. Some groups covered by Medicaid are: pregnant women, children, people with disabilities, and people age 65 and older.

Medicaid and FAMIS Plus are programs funded by the state and federal governments. Not everyone with high medical bills qualifies. The eligibility rules may be different for children, adults, and people in nursing facilities, but all people within a group are treated the same.

How Do I Apply?

To apply for Medicaid and FAMIS Plus, contact the Department of Social Services (DSS) in the city or county where you live. The phone number for your local DSS can be found in the blue pages of your phone book. A face-to-face interview is not required. An application must be signed by the person who needs assistance unless it is completed and signed by the applicant's legal guardian, conservator, attorney-in-fact, or authorized representative. Applications can be filed at some larger hospitals as well. A parent, guardian, authorized adult representative, or caretaker relative with whom the child lives must sign applications for children under the age of 18. Children under the age of 18 cannot apply for themselves. However, if a child under the age of 18 has a child of their own, he/she can file an application for the child.

You may use the Department of Social Services screening tool on their website (**http://dssiad.dss.state.va.us/EligibilityScreening)** to help determine whether you are eligible for Medicaid or children's health insurance, but the final decision must be made by an eligibility worker at your local department of social services.

*The Federal Poverty Income Guidelines are available on the DMAS website at **http:// http://www.dmas.virginia.gov/pr-home.htm**

What Will I Be Asked?

Applicants for Medicaid are asked to provide their Social Security number, confirm they are a Virginia resident, confirm U.S. citizenship or provide documentation of alien status, and verify income and resources. Resources are not evaluated and are not a required verification for FAMIS Plus and pregnant women. If you claim to be unable to work due to a disability, you will be asked whether you have applied for disability benefits. If you have not, you may be asked further information about your medical condition. If you claim to be pregnant, you will be asked to provide proof of pregnancy, such as the written medical results (documentation) of your pregnancy test.

Who Makes A Decision, And How Long Does It Take?

The Department of Social Services staff will determine whether you meet a Medicaid covered group (see section on Covered Groups) and if your resources and income are within required limits after they receive a signed application. The amount of income and resources you can have and still be eligible for Medicaid depends on how many people you have in your family and the limits established for your covered group.

An eligibility decision will be made on your Medicaid application: (1) within 45 calendar days, (2) within 90 calendar days if a disability decision is needed, or (3) within 10 working days of the agency's receipt of the signed application if all necessary documentation has been provided to determine eligibility for pregnant women. The local Department of Social Services will send you a written notice that your application has either been approved or denied. If you disagree with the decision made by the local DSS, you may file an appeal (see section on When and How to File and Appeal).

When Does Medicaid Start?

Medicaid eligibility usually starts on the first day of the month in which you apply and are found to be eligible. Medicaid can start as early as three months before the month in which you applied if you meet all eligibility requirements and received a medical service during that time. Coverage under the Qualified Medicare Beneficiary (QMB) group always starts the month after the approval action. Contact your local Department of Social Services office if you have questions about when your Medicaid coverage starts.

How Do I Keep My Coverage?

Once you or your child is approved for Medicaid or FAMIS Plus you or your child will be covered for 12 months, provided that you or your child continues to meet eligibility requirements. Most people must have their Medicaid or FAMIS Plus coverage reviewed annually (at least once every 12 months) to determine if they are still eligible for the program. If this annual review is not completed your coverage will be canceled and you may have to pay for any medical care you or your child receives.

When your annual review is due, the Department of Social Services will send you a notice. They may ask you to complete a form and supply proof of your current income so they can complete the review or they may have already reviewed your eligibility for another 12 months using information they have available.

If you are notified to complete a form or send in proof of income, it is very important that you do so immediately. If you do not provide the information in time, the Medicaid or FAMIS Plus will be canceled. If the Department of Social Services is able to renew Medicaid or FAMIS Plus with information they already have, you will receive a notice telling you the coverage has been continued and the date of your next annual renewal. If you need assistance completing the forms, contact your eligibility worker.

Sometimes your Medicaid or FAMIS Plus may be reviewed before the end of the 12 months. **REMEMBER** -You must report any change in circumstances within 10 calendar days of the change. If the reported change affects your eligibility for Medicaid or FAMIS Plus, your case will be reviewed at that time and you will be notified of the outcome. If you apply or are reviewed for another program provided by social services, such as Food Stamps or TANF, it is possible the eligibility worker will go ahead and renew your Medicaid/FAMIS Plus at the same time and extend your coverage for another 12 months from that date.

IT IS VERY IMPORTANT to tell your local Department of Social Services right away if you move or change your address. If they do not have a correct address, you will not receive any notice when it is time to renew Medicaid or FAMIS Plus and your coverage will be canceled. If you move or change your address at any time, contact your local Department of Social Services right away to protect your coverage

COVERED GROUPS FOR FULL COVERAGE

Federal and state laws describe the groups of people who may be eligible for Medicaid. These groups of people are called Medicaid covered groups. The eligibility rules and medical services available are different for certain covered groups. People who meet one of the covered groups may be eligible for Medicaid coverage if their income and resources are within the required limits of the covered group. The Medicaid covered groups are:

- Aged, blind, or disabled individuals with income up to 300% of the Supplemental Security Income (SSI) payment rate who have been screened and approved to receive services in a nursing facility or through one of the Medicaid Home and Community-Based Care Waivers;
- Auxiliary Grants (AG) enrollees in Assisted Living Facilities;
- Certain people who lost SSI because their income or living situation changed;
- Certain refugees for a limited time period;
- Children from birth to age 19 whose family income is at or below 133% of the Federal Poverty Income Guidelines*; children from birth to age 19 whose family income is above 133% of the Federal Poverty Income Guidelines* may qualify for FAMIS;
- Children under age 21 who are in foster care or subsidized adoptions;
- Individuals age 65 or older, blind, or disabled who have income that does not exceed 80% of the Federal Poverty Income Guidelines*;
- Infants born to Medicaid-eligible women (including those whose labor and delivery was covered under Medicaid as an "emergency service")
- Low Income Families with Dependent Children (LIFC);
- Medically Needy Individuals who meet Medicaid covered group requirements but have excess income;
- Persons who are terminally ill and have elected to receive hospice care;

- Pregnant women (single or married) whose family income is at or below 133% of the Federal Poverty Income Guidelines*;
- Supplemental Security Income (SSI) enrollees who are age 65 or older, blind, or disabled (unable to work due to severe medical conditions) and meet Medicaid resource limits; and
- Women screened by the Centers for Disease Control and Preventions' National Breast and Cervical Cancer Early Detection Program who have been diagnosed and need treatment for breast or cervical cancer.

LIMITED COVERAGE GROUPS

Medicare-Related Covered Groups

Individuals who are eligible for Medicare and who meet one of the following covered groups may receive limited Medicaid coverage. Medicaid pays the Medicare premium on behalf of these Medicare beneficiaries:

- **Qualified Medicare Beneficiaries (QMBs)** must be eligible for Medicare Part A. Their income must be at or below 100% of the Federal Poverty Income Guidelines and their resources must be not more than $4,000 for a single person and $6,000 for a couple. Medicaid pays the Medicare Part A and Part B premiums and the coinsurance and deductibles that Medicare does not pay.

- **Special Low-Income Medicare Beneficiaries (SLMBs)** must be eligible for Medicare Part A. Their income must be between 100% and 120% of the Federal Poverty Income Guidelines and their resources must not be more than $4,000 for a single individual and $6,000 for a couple. Medicaid pays the Medicare Part B premiums.

- **Qualified Individuals (QI)** must be eligible for Medicare Part A. Their income must equal or exceed 120% but be less than 135% of the Federal Poverty Income Guidelines. Their resources must be at or below $4,000 for a single person and $6,000 for a couple. Medicaid pays the Medicare Part B premiums.

- **Qualified Disabled and Working Individuals (QDWIs)**—Medicaid can pay Medicare Part A premiums for certain disabled individuals who lose Medicare coverage because of work. These individuals must have income below 200% of the federal poverty income guidelines and resources that are no more than twice the standard allowed under SSI.

Family Planning Waiver Services

Women who receive Medicaid-paid pregnancy-related services and whose income is less than or equal to 133% of the federal poverty level are eligible to receive family planning waiver services for 24 months following the end of the pregnancy. Coverage is limited to the following services: annual gynecological exams, family planning education

and counseling, FDA approved contraceptives, including over-the-counter contraceptives, sexually transmitted disease screening at the initial family planning visit, and sterilization (not including hysterectomy). Any family planning waiver recipient needing other health services not covered by the family planning waiver will be referred to the Virginia Primary Care Association, the local Health Department, and/or the Virginia Association of Free Clinics to obtain primary or routine medical care services if they are not otherwise eligible for Medicaid after pregnancy. Primary care services are the responsibility of the family planning waiver services recipient, who may be charged a reduced rate or a sliding scale fee for such services.

Emergency Services to Aliens

Special rules apply to non-citizens. If a person meets one of the covered groups listed above but is not a U.S. citizen, his immigration status and date of entry into the U.S. determine his eligibility for full Medicaid coverage. If the alien's immigration status prohibits full Medicaid coverage, he can only be approved for emergency medical treatment.

FINANCIAL RULES

Resources

When applying for Medicaid, you must disclose all financial resources that you own. Resources include money on hand, in the bank, and in a safe deposit box; stocks, bonds, certificates of deposit, trusts, or pre-paid burial plans. Resources also include cars, boats, life insurance policies, and real property. **All resources must be reported.** However, not all resources are counted in deciding eligibility for Medicaid. For example, the house that you own and live in is not a countable resource for Medicaid purposes.

If the value of your resources is more than the Medicaid resource limit when you apply for Medicaid coverage, you may become eligible for Medicaid by reducing your resources to or below the limit. **Resources that are sold or given away for less than what it is worth may cause you to be found ineligible for Medicaid coverage of long-term care services for a certain period of time.** You will be asked to describe all transfers of assets that have occurred within the past three years and any trust fund you have set up within the past five years. This can include such actions as transferring the title to a vehicle, removing your name from a property deed, or giving a substantial amount of money to a family member.

Income

You must disclose all income that you receive. Income includes earned income, such as wages, as well as unearned income such as Social Security, retirement pensions, veteran's benefits, child support, etc. Income is added together and compared to established limits to determine eligibility.

The income limits vary according to the covered group and the type of coverage. For some groups, the income limits vary depending on the county or city where you live. Total income is evaluated, deductions are allowed according to Medicaid policy, and the amount of income remaining is compared to the appropriate Medicaid limit. The amount of your debts or bills that you owe is not used in determining whether your income is within the Medicaid limit.

If you meet all Medicaid requirements, but you have excess income, you can reduce (spenddown) your excess income by incurring medical expenses. This group is referred to as **Medically Needy**. Your income is compared to a limit based on the area of the state in which you reside. A deductible (spenddown) is calculated, usually for a six-month period. Current and some old unpaid medical bills can be used as deductions against the spenddown amount. Coverage starts only after the spenddown amount is reduced to zero, and runs through the end of the spenddown period. You can then reapply for another period of coverage.

MEDICAID AND OTHER INSURANCE

You can keep private health insurance and still be covered by Medicaid or FAMIS Plus. If you have other insurance, the other insurance plan pays first. Having other health insurance does not change the co-payment amount you will pay to providers as a Medicaid recipient. If you have a Medicare supplemental policy, you can suspend your policy for up to 24 months while you have Medicaid without penalty from your insurance company. You must notify the insurance company within 90 days of the end of your Medicaid coverage to reinstate your supplemental insurance.

FRAUD AND OTHER RECOVERIES

Medicaid fraud is a deliberate withholding or hiding of information or giving false information to get Medicaid or FAMIS Plus benefits. Medicaid fraud also occurs when a provider bills Medicaid for services that were not delivered to a Medicaid recipient, or if a recipient shares his/her Medicaid number with another person to get medical care.

Anyone convicted of Medicaid fraud in a criminal court must repay the Medicaid program for all losses (paid claims and managed care premiums) and cannot get Medicaid for one year after conviction. In addition, the sentence could include a fine up to $25,000 and/or up to 20 years in prison. You may also have to repay the Medicaid program for any claims and managed care premiums paid during periods you were not eligible for Medicaid due to acts not considered criminal. Fraud and abuse should be reported to your local Department of Social Services or to the Department of Medical Assistance Services Recipient Audit Unit at (804) 786-0156.

YOUR RIGHTS AND RESPONSIBILITIES

You have the right to …

- file an application for assistance.
- receive written information about specific eligibility policies.
- have a decision made promptly.
- receive a written notice of the decision.
- have your personal and health information kept private.
- file an appeal.

You have the responsibility to…

- complete the application and renewal forms fully and accurately.
- supply requested information, or to advise of any problems you are having in getting the necessary information.
- immediately report changes in your circumstances such as moving, new employment, birth or death of a child, marriage, adding or dropping other insurance, or changes in resources and monthly income.
- inform your eligibility worker of any other medical insurance that may cover some of your bills.

MEDICAID OR FAMIS PLUS CARDS

When you are found eligible, you will be mailed a blue and white plastic Medical Assistance Eligibility Card (Medicaid or FAMIS Plus card), which contains your name and identification number. **It is your responsibility to show your Medical Identification Card to providers at the time you go for services and to be sure the provider accepts payment from Virginia Medicaid.** If you have a Medicaid or FAMIS Plus card because you were eligible at an earlier time, that card will be valid again when your coverage is reinstated.

Co-payments

Some Medicaid enrollees must pay a small amount for certain services. This is called a co-payment.

The following people do not pay a co-payment for services covered by Medicaid:

- Children younger than age 21;
- People receiving institutional or community-based care, long-term care services (patient pay may be applicable); and
- People in hospice programs.

The following services are not subject to co-payments:

- Emergency services (including dialysis treatments);
- Pregnancy-related services;
- Family-planning services; and
- Emergency room services.

Medicaid charges co-payments for the following:

Service	Co-Payment Amount
Inpatient hospital	$100.00 per admission
Outpatient hospital clinic	$3.00 per visit
Clinic visit	$1.00 per visit
Physician office visit	$1.00 per visit
Other physician visit	$3.00 per visit
Eye examination	$1.00 per examination
Prescription	$1.00 for multi-source generic; $3.00 for brand names per prescription or refill
Home health visit	$3.00 per visit
Rehabilitation service	$3.00 per visit

A medical provider cannot refuse to treat you or provide medical care if you are not able to pay the co-payment. However, you are still responsible for paying the co-payment.

HOW MEDICAID BENEFITS ARE ACCESSED

Most Virginia Medicaid enrollees are required to receive their medical care through managed care programs; however, some enrollees receive their care through providers enrolled directly with the Department of Medical Assistance Services (DMAS). If you meet the criteria to be assigned to managed care, you will receive a package of information. You will have approximately one month to choose a MEDALLION Primary Care Provider (PCP) or a Managed Care Organization (MCO).

In MEDALLION, you will be assigned to a PCP who will provide primary health care services, give you referrals to other health care providers when needed, and monitor your health. An MCO is a health service organization that coordinates health care services through a network of providers. You also will receive a permanent MCO identification card to use with the plastic Medicaid ID card. **Please keep both cards with you.** The MCO will require you to choose a PCP in their network who will manage all of your health care needs.

SERVICES FOR CHILDREN

Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) is a special Medicaid program for children enrolled in Medicaid or FAMIS Plus up to the age of 21 that detects and treats health care problems early through:

- ✓ Regular medical, dental, vision, and hearing check-ups
- ✓ Diagnosis of problems
- ✓ Treatment of dental, eye, hearing, and other medical problems discovered during check-ups

EPSDT exams (check-ups) are done by your child's doctor and must include:

- ✓ A complete history of your child's health, nutrition, and development
- ✓ A head-to-toe physical exam
- ✓ Health education
- ✓ A growth and development check
- ✓ Lab tests
  *All children are at risk for lead poisoning and must be screened
- ✓ Shots/immunizations, as needed
- ✓ Eye check-up
- ✓ Ear check-up
- ✓ Dental check-up and a referral to a dentist by the age of three
  *Dental check-ups with a dentist should be done every 6 months

You should visit your child's doctor for check-ups early and on a regular basis.

Use the chart below to find out when your child should receive regular check-ups:

AGE	CHECK-UP SCHEDULE
Under 1 year old (Infants)	Check-up needed for newborns, under six weeks, and at ages 2, 4, 6, and 9 months
1-2 years old (Toddlers)	Check-up needed at ages 12, 15, and 18 months
2-4 years old (Early Childhood)	Check-up needed at ages 2, 3, and 4 years Schedule dental visits every 6 months after your child's third birthday.
5-10 years old (Late Childhood)	Check-up needed at ages 5, 6, 8, and 10 years
12-20 years old (Teens)	Check-up needed at ages 12, 14, 16, 18, and 20 years

Shots (Immunizations) may be part of your child's check-up.

Use the chart below to find out when and what shots your child should receive:

AGE	SHOT
Birth-2 months	Hep B (hepatitis B)
1-4 months	Hep B
2 months	DTaP (diphtheria, tetanus, and pertussis), IPV (polio), Hib (*Haemophilus influenza* type b)
4 months	DTaP, IPV, Hib
6 months	DTaP, Hib
6-18 months	Hep B, OPV (polio)
12-15 months	Hib, MMR (measles, mumps and rubella)
12-18 months	Var (chickenpox)
15-18 months	DTaP
Before starting school (4-6 years)	MMR, DTaP, OPV
11-12 years	**MMR** (if your child has not had the MMR shots) **Var** (if your child has not had the chickenpox shot and has never had chickenpox) **Hep B** (if your child has not had the hepatitis B shots)
11-16 years	Td (tetanus, diphtheria)

*Be sure each of your child's shots is recorded on a shot record. Take your child's shot record with you to every check-up.

If your child's doctor finds a health problem during an EPSDT check-up, he may be able to treat the problem or may send you to another provider (specialist) who can treat it.

EPSDT IS FREE:

- ✓ Medicaid will pay for the EPSDT check-ups.
- ✓ Medicaid will pay for the treatment of dental, vision, hearing, and other medical problems, found during a check-up.
- ✓ Medicaid will provide transportation, if needed, by calling toll-free at 1-866-386-8331.

If a treatment or service is needed to correct, improve a problem that is found during an EPSDT check-up, or prevent a problem from getting worse, talk with your child's doctor. There are services covered through EPSDT that are not normally covered by Medicaid. Your child may be referred for medically necessary specialty care or other health services if the PCP or screening provider is not able to provide the treatment.

Other Related Programs

- Prenatal Care

The Department's Prenatal Program assists pregnant women in Medicaid to access medical, social, educational, and other services that may affect the pregnancy outcome. Pregnant women and infants who are identified by the PCP or other physicians as high-risk for poor medical outcomes may be referred to a maternal and infant care coordinator (MICC) or their MCO for the duration of the pregnancy, including 60 days postpartum and up to age two for infants.

Additional information on prenatal programs may be obtained from your PCP, your MCO or the Local Health Department.

- Special Supplemental Nutrition Program for Women, Infants, and Children (WIC)

WIC is a supplemental food and nutrition education program that provides vouchers for the purchase of specific nutritious foods. It provides nutrition counseling to pregnant, postpartum, or breastfeeding women, infants, and children under age five with nutritional and financial needs. Your child's doctor or EPSDT screening providers must refer eligible infants and children to the local health department for additional information and a WIC eligibility determination.

The Virginia Department of Health's Nutrition Services Team is committed to practicing and promoting good health. Contact them by calling 1-888-942-3663

- Head Start

Head Start is a federally funded pre-school program that serves low-income children and their families. Contact your local school division for more information.

- Healthy Start

Some communities in Virginia have high percentages of low birth weights, late-term miscarriages, infant deaths, and births to teenage mothers. Pregnant women in these areas are often unable to see doctors because they don't have insurance or enough insurance. The Virginia Healthy Start Initiative (VHSI) is designed to reduce infant mortality in these urban and rural areas and small towns: Norfolk, Petersburg, Portsmouth, and Westmoreland County.

Information about Healthy Start can be obtained by contacting the Healthy Start Program Coordinator at the VDH Division of Women's and Infant's Health at 1-804-864-7764.

- Early Intervention Program

Early intervention services, also known as “Part C” of the Individuals with Disabilities Act (IDEA), are available throughout Virginia to help infants and toddlers, under age 3 who have developmental delays or disabilities, and their families.

For more information, contact: Babies Can’t Wait Program, Virginia Department of Mental Health, Mental Retardation and Substance Abuse Services Early Intervention Office (1-800-234-1448).

- Resource Mothers Program

Teenagers are a group at high risk for poor birth outcomes, both medically and socially. The Resource Mothers Program trains and supervises laywomen to serve as a social support for pregnant teenagers and teenage parents of infants. The program helps low-income pregnant teenagers get prenatal care and other community services, follow good health care practices, continue in school, and encourage the involvement of the infant’s father and teens’ parents to create a stable, nurturing home. For further information, contact the Division of Women’s and Infants’ Health, Virginia Department of Health at (804) 864-7751.

- Linkages with Schools

Schools are key links in improving child health because they are in regular contact with students and parents. Schools play an important role in identifying children’s health problems and improving access to a wide range of health care services. Schools help to inform eligible children and families about Medicaid and the EPSDT Program.

LONG-TERM CARE AND WAIVER SERVICES

Medicaid pays for care in some institutional settings, such as nursing facilities and Intermediate Care Facilities for the Mentally Retarded. Long-term care may also be provided to individuals in their communities through Home and Community Based-Care Waivers. To qualify for institutional or community long-term care services, an individual must meet certain level-of-care requirements. These requirements may include assistance with activities of daily living and/or a medical nursing need. There are different eligibility rules and requirements such as: pre-admission screening, asset transfer, and patient pay, which only apply to individuals who need Medicaid coverage for long-term care services. Contact your local Department of Social Services for details if Medicaid long-term care services are being considered.

Pre-Admission Screening

This screening determines whether an individual meets the level-of-care criteria for long-term care services. Screening is not required if the person is already in a nursing

facility or is entering the facility directly from another state. Pre-admission screenings for institutional and community-based long term care are completed by the following teams:

- local teams composed of health and social service agencies;
- staff of acute care hospitals;
- Community Services Boards; and/or
- Child Development Clinics.

Asset Transfer

Medicaid applicants or enrollees who transfer (sell, give away, or dispose of) assets without receiving adequate compensation may be ineligible for Medicaid payment of long-term care services for a period of time. You will be asked about any assets you have transferred in the last 36 to 60 months. Some asset transfers may not result in ineligibility depending on the circumstances or if the Medicaid program determines that the denial of Medicaid eligibility would cause an undue hardship. Transfers occurring after enrollment in Medicaid may also result in a penalty for payment of your long-term care services.

Because the asset transfers policy is very complex, contact your local Department of Social Services if you have further questions regarding the impact of property transfer upon Medicaid eligibility. Department of Social Services staff will not advise an individual to take any specific course of action to achieve Medicaid eligibility, but they can provide you with detailed policy information.

Special Rules for Married Institutionalized Individuals

Medicaid uses special rules to determine Medicaid eligibility when one member of a married couple receives long-term care and the other does not. These rules are referred to as spousal impoverishment protections. Resources and income are evaluated to determine how much can be reserved for the spouse who remains at home without affecting the Medicaid eligibility of the other spouse.

A resource assessment can be requested when a spouse is admitted to a medical institution. A resource assessment must be completed when a married institutionalized individual, who has a spouse in the community, applies for Medicaid.

Home and Community-Based Waivers

Virginia provides a variety of services under home and community-based waivers to specifically targeted individuals, such as personal care. Each waiver provides specialized services to help certain individuals to remain in their communities. The six waivers available are:

- AIDS Waiver - provides care in the community rather than in a hospital or nursing facility for individuals who are experiencing medical and functional symptoms associated with HIV/AIDS.

- Consumer-Directed Personal Attendant Services (CD-PAS) Waiver - provides care in the community rather than in a nursing facility for disabled or elderly individuals who meet the level of care criteria and are determined to be at risk of nursing facility placement. Community-based care services must be the critical service that enables the individual to remain at home rather than being placed in a nursing facility. Individuals in this waiver direct their own care and hire their attendants. Individuals who have cognitive impairments may have someone else direct their care if they are not able.

- Elderly and Disabled Waiver (E&D) - provides care in the community rather than in a nursing facility for individuals who meet the nursing facility level of care criteria. Services offered in this waiver include personal assistance, respite (including skilled respite), adult day health care, and personal emergency response system services.

  Elderly or Disabled with Consumer Direction (EDCD) Waiver (Effective February 1, 2005). This waiver combines the Elderly and Disabled (E&D) and the Consumer Directed Personal Attendant Services (CD-PAS) Waivers.

  The EDCD Waiver is designed to provide individuals with choices of either agency or consumer-directed personal and respite care, as well as agency-directed skilled respite care and personal emergency response system (PERS). There are several components of the EDCD Waiver. The waiver will:
  - Allow elderly or disabled waiver beneficiaries to receive both agency and consumer directed service options in one program as long as it is appropriate and duplicate services are not provided;
  - Allow individuals to direct their own care or have a spouse, adult child, parent, or guardian direct their care;
  - Allow employed individuals to keep a larger portion of their earned income.

- Individual and Family Developmental Disabilities (DD) Support Waiver - provides care in the community rather than in an Intermediate Care Facility for the Mental Retarded (ICF/MR) for individuals who are 6 years of age and older who have a condition related to mental retardation who (1) meet the ICF/MR level of care criteria (i.e., they meet two out of seven levels of functioning in order to qualify); (2) are determined to be at imminent risk of ICF/MR placement, and (3) are determined that community-based care services under the waiver are the critical services that enable the individual to remain at home rather than begin placed in an ICF/MR.

- Mental Retardation (MR) Waiver - provides care in the community rather than in an Intermediate Care Facility for the Mental Retarded (ICF/MR) for individuals who are up to 6 years of age who are at developmental risk and individuals age 6 and older who have mental retardation.

- Technology Assisted (Tech) Waiver - provides care in the community rather than in a nursing facility for individuals who are dependent upon technological support and require substantial, ongoing nursing care.

Please contact your local Department of Social Services, Community Services Boards, or DMAS for further information.

MEDICAL CARE UNDER MEDICAID AND FAMIS PLUS

Most medical care, both inpatient and outpatient, is covered by Medicaid. There are certain limits and rules that apply. For example, some medical procedures must be performed as outpatient surgery unless there is a medical need for hospital admission. Care in an institution for the treatment of mental diseases is not covered for people between the ages of 21-64. Routine dental care for adults is not covered. There are limits to the number of visits approved for home health, psychiatric services, and other professional services. Some services require prior authorization.

Pharmacy

Medicaid has a preferred drug list (PDL), but drugs not on the list can be covered if pre-authorized. The PDL Program offers a process in which the pharmacist may provide a 72-hour supply of a non-preferred medication if your physician is not available to give prior authorization or change to a preferred medication (including after hours, weekends, holidays). The pharmacist must determine if your health would be at risk without the drug and is not required to provide the prescription unless there is an urgent need. You will be charged a co-payment for the 72-hour supply; however, a co-payment will not be charged when you receive the remainder of the prescription.

Prescriptions are filled with no more than a 34-day. When available, generic drugs are given unless the doctor specifies that a particular brand name is medically necessary. Some over-the-counter drugs can be covered if ordered by a doctor instead of a prescription drug.

If you have questions about the PDL, call First Health at 1-800-932-3923 or talk to your doctor.

Transportation

Transportation services are provided when necessary to help people access Medicaid covered services. Medicaid covers two types of transportation:

- **Emergency -** Medicaid pays for emergency transportation to receive medical treatment.

- **Non-Emergency –** All non-emergency medical transportation is provided through a transportation broker or through your Managed Care Organization.

Transportation is provided if you have no other means of transportation, and need to go to a physician or a health care facility. Your medical condition should not be life threatening. In case of a life-threatening emergency, call 911.

Call the reservation line at 1-866-386-8331 at least 48 hours (2 days) prior to the scheduled medical appointment. (Verifiable urgent trips, like hospital discharges, may be accepted with less than 48 hours notice.) Please have your Medicaid ID number available when you call.

Remember:
Trips must be medically necessary. Examples: doctor appointment, counseling, dialysis, dental appointment.

What is Not Covered by MEDICAID and FAMIS Plus

- Abortions, unless the pregnancy is life-threatening or health-threatening;
- Acupuncture;
- Administrative expenses, such as completion of forms and copying records;
- Alcohol and drug abuse therapy (except as provided through EPSDT or for pregnant women through the Community Services Boards and under the BabyCare program);
- Artificial insemination, in-vitro fertilization, or other services to promote fertility;
- Broken appointments;
- Certain drugs not proven effective and those offered by non-participating manufacturers (enrolled doctors, drugstores, and health departments have lists of these drugs);
- Certain experimental surgical and diagnostic procedures;
- Chiropractic services;
- Cosmetic treatment or surgery;
- Day care, including sitter services for the elderly (except in some home- and community-based service waivers);
- Dentures for enrollees age 21 and over;
- Doctor services during non-covered hospital days;
- Drugs prescribed to treat hair loss or to bleach skin;
- Eyeglasses or their repair for enrollees age 21 or older;
- Friday or Saturday hospital admission for non-emergency reasons or admission for more than one day prior to surgery unless the admission on those days is pre-authorized;
- Hospital charges for days of care not authorized for coverage;
- Immunizations if you are age 21 or older (except for flu and pneumonia for those at risk);
- Inpatient hospital care in an institution for the treatment of mental disease for enrollees under age 65 (unless they are under age 22 and receiving inpatient psychiatric services);
- Medical care received from providers who are not enrolled in or will not accept Virginia Medicaid;

- Personal care services (except in some home and community-based service waivers or under EPSDT);
- Private duty nursing (except in some home and community-based service waivers or under EPSDT);
- Psychological testing done for school purposes, educational diagnosis, school, or institution admission and/or placement or upon court order;
- Remedial education;
- Routine dental care if you are age 21 or older;
- Routine school physicals or sports physicals;
- Sterilization of enrollees younger than age 21;
- Telephone consultation; and
- Weight loss clinic programs.

Once you are found eligible, if you receive a service not covered by Medicaid or you receive more services than the Medicaid limit for that service, you will have to pay those bills.

Out-of-State Medical Coverage

Virginia Medicaid covers emergency medical services while an enrolled person is temporarily outside of Virginia if the provider of care agrees to participate in Virginia's Medicaid Program and to bill Medicaid. Virginia Medicaid does not cover medical care rendered outside of the United States.

WHEN AND HOW TO FILE AN APPEAL

You have the right to request an appeal of any action related to initial or continued eligibility for Medicaid or FAMIS Plus. This includes delayed processing of your application, actions to deny your request for medical services, or actions to reduce or terminate coverage after your eligibility has been determined.

To request an appeal, notify DMAS in writing of the action you disagree with within 30 days of receipt of the agency's notice about the action. You may write a letter or complete an Appeal Request Form. Forms are available on the Internet at www.dmas.virginia.gov.

Please be specific about what action or decision you wish to appeal and include a copy of the notice about the action if you have it. Be sure to sign the letter or form.

Please mail appeal requests to:

Appeals Division
Department of Medical Assistance Services
600 E. Broad Street
Richmond, Virginia 23219
Telephone: (804) 371-8488
Fax: (804) 371-8491

For reduction or termination of coverage, if your request is made before the effective date of the action and the action is subject to appeal, your coverage may continue pending the outcome of the appeal. You may, however, have to repay any services you receive during the continued coverage period if the agency's action is upheld.

After you file your appeal, you will be notified of the date, time, and location of the scheduled hearing. Most hearings can be done by telephone.
The Hearing Officer's decision is the final administrative decision rendered by the Department of Medical Assistance Services. However, if you disagree with the Hearing Officer's decision, you may appeal it to your local circuit court.

IMPORTANT ADDRESSES AND PHONE NUMBERS

Local Department of Social Services in your City or County

Check the government (blue) pages of your local telephone book for the proper contact number for the following information:

- Questions about applying for Medicaid, FAMIS Plus, or your eligibility for the program.
- Report a change in residence, income, or other significant event.
- Questions about pre-admission screening for long-term care services.
- Request Fact Sheets about Medicaid eligibility.

Virginia Department of Social Services

For questions or complaints regarding the actions of staff employed by the local Department of Social Services, write the Virginia Department of Social Services, Bureau of Customer Service, 7 North Eighth Street, Richmond, Virginia 23219. You can also call the customer services hotline at 1-800-552-3431 or email your concern to citizen.services@dss.virginia.gov.

Department of Medical Assistance Services

- For Medicaid Waiver Programs, call (804) 786-1465.
- To report Medicaid fraud or abuse, call the DMAS Recipient Audit Unit at (804) 786-0156 or your local Department of Social Services.
- For Medicaid appeal information, call (804) 371-8488.

Internet Website Information

- Virginia Department of Health—www.vdh.virginia.gov
- Virginia Department of Medical Assistance Services—www.dmas.virginia.gov
- Virginia Department of Social Services—www.dss.virginia.gov
- Centers for Medicare and Medicaid Services—www.cms.hhs.gov

PRIVACY INFORMATION

Under the Health Insurance Portability and Accountability Act (HIPAA) of 1996, your health information is protected. DMAS may use and disclose your protected health information to carry out treatment, payment, or health care operations, and for other purposes that are permitted or required by state or federal law. The law also describes your rights to access and control your protected health information. "Protected health information" is information related to your past, present, or future physical or mental health or condition and related health care services, including demographics that may identify you.

DMAS is required to abide by the terms of the Notice of Privacy Practices currently in effect. We may change the terms of our notice at any time. The new notice will be effective for all protected health information that we maintain at that time and will be posted at the DMAS office. Upon your request, we will provide you with a revised Notice of Privacy Practices. You may request a revised Notice of Privacy Practices by accessing our website at www.dmas.virginia.gov or calling the DMAS office at (804) 786-4231 and requesting that a revised copy be sent to you by mail. We retain revisions of the Notice of Privacy Practices for six (6) years.

For a free copy of more detailed information regarding your protected health information rights, please call (804) 786-4231.

If you believe your privacy rights have been violated, you may file a complaint with DMAS or with the Secretary of the U.S. Department of Health and Human Services. To file a complaint with DMAS, you may contact: DMAS Office of Privacy & Security at (804) 225-2860 for further information about the complaint process. You will not be penalized for filing a complaint.

1. USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

Uses and Disclosures of Protected Health Information Based Upon Your Written Consent

You will be asked by your physician to sign a consent form. Once you have signed the consent form, your physician will use or disclose your protected health information for purposes of diagnosis, treatment, obtaining payment for your health care bills, or to conduct health care operations.

This Notice of Privacy Practices will tell you the ways in which the Department of Medical Assistance Services will use and disclose medical information about you. We will also describe your rights and certain obligations we have regarding the use and disclosure of medical information.

For Treatment: We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, medical students, or other hospital personnel who are involved in taking care of you at the hospital. For example, a doctor treating you for a broken leg may need to know if you have diabetes, because diabetes may slow the healing

process. In addition, the doctor may need to tell the dietitian if you have diabetes so that we can arrange for appropriate meals. Different departments of the hospital also may share medical information about you in order to coordinate the different things you need, such as prescriptions, lab work, and x-rays. We also may disclose medical information about you to people outside the hospital who may be involved with your medical care after you leave the hospital.

For Payment: We may use and disclose medical information about you so that the treatment and services you receive at the hospital may be billed to you and payment may be collected from you, an insurance company, or a third party. For example, we may use your medical information from a surgery you received at the hospital so that the hospital can be reimbursed. We may also use your information to obtain prior approval for a treatment you may receive or to determine whether some other third party will cover the treatment.

For Health Care Operations: We may use and disclose medical information about you for medical operations. These uses and disclosures are necessary to make sure all patients receive quality care. For example, we may use medical information to review your treatment and services and to evaluate the performance of the staff caring for you. We may also combine medical information about many patients to decide what additional services should be covered, what services are not needed, and whether certain new treatments are effective. We may also disclose information to doctors, nurses, technicians, medical students, and other hospital personnel for review and learning purposes. We may also combine the medical information we have with medical information from other health plans to compare how we are doing and see where we can make improvements in the care and services we offer. We may remove information that identifies you from this set of medical information so others may use it to study health care and health care delivery without learning the identity of the patients.

Other Permitted and Required Uses and Disclosures That May Be Made Without Your Consent, Authorization, or Opportunity to Object

We may use or disclose your protected health information in the following situations without your consent or authorization:

- **Required By Law:** We may use or disclose your protected health information to the extent that the use or disclosure is required by law. The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law. You will be notified, as required by law, of any such uses or disclosures.

- **Emergencies:** We may use or disclose your protected health information in an emergency treatment situation. If this happens, your physician shall try to obtain your consent as soon as reasonably practicable after the delivery of treatment. If your physician or another physician in the practice is required by law to treat you and the physician has attempted to obtain your consent but is unable to obtain your consent, he or she may still use or disclose your protected health information to treat you.

- **Communication Barriers:** We may use and disclose your protected health information if your physician or another physician in the practice attempts to obtain consent from you but is unable to do so due to substantial communication barriers. The physician will determine, using professional judgment, what you intended to consent to use or disclosure under the circumstances.

- **Public Health:** We may disclose your protected health information for public health activities and purposes to a public health authority that is permitted by law to collect or receive the information. The disclosure will be made for the purpose of controlling disease, injury or disability. We may also disclose your protected health information, if directed by the public health authority, to a foreign government agency that is collaborating with the public health authority.

- **Communicable Diseases:** We may disclose your protected health information, if authorized by law, to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition.

- **Health Oversight:** We may disclose protected health information to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, other government regulatory programs, and civil rights laws.

- **Abuse or Neglect:** We may disclose your protected health information to a public health authority that is authorized by law to receive reports of child abuse or neglect. In addition, we may disclose your protected health information if we believe that you have been a victim of abuse, neglect, or domestic violence to the governmental entity or agency authorized to receive such information. In this case, the disclosure will be made consistent with the requirements of applicable federal and state laws.

- **Food and Drug Administration:** We may disclose your protected health information to a person or company required by the Food and Drug Administration to report adverse events, biologic product deviations, product defects or problems; to track products, to enable product recalls, to make repairs or replacements, or to conduct post-marketing surveillance, as required.

- **Legal Proceedings:** We may disclose protected health information in the course of any judicial or administrative proceeding in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized), and in certain conditions in response to a subpoena, discovery request, or other lawful process.

- **Law Enforcement:** We may also disclose protected health information, so long as applicable legal requirements are met, for law enforcement purposes. These law enforcement purposes include (1) legal processes and purposes otherwise required by law, (2) limited information requests for identification and location purposes, (3)

treating victims of a crime, and (4) suspicion that death has occurred as a result of criminal conduct.

- **Coroners, Funeral Directors, and Organ Donation:** We may disclose protected health information to a coroner or medical examiner for identification purposes, determining cause of death or for the coroner or medical examiner to perform other duties authorized by law. We may also disclose protected health information to funeral directors, as authorized by law; in order to carry out funeral-related duties. We may disclose such information in reasonable anticipation of death. Protected health information may be used and disclosed for cadaveric organ, eye, or tissue donation purposes.

- **Research:** We may disclose your protected health information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your protected health information.

- **Criminal Activity:** Consistent with applicable federal and state laws, we may disclose your protected health information, if we believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. We may also disclose protected health information if it is necessary for law enforcement authorities to identify or apprehend an individual.

- **Military Activity and National Security:** When the appropriate conditions apply, we may use or disclose protected health information of individuals who are Armed Forces personnel (1) for activities deemed necessary by appropriate military command authorities; (2) for the purpose of a determination by the Department of Veterans Affairs of your eligibility for benefits, or (3) to foreign military authority if you are a member of that foreign military service. We may also disclose your protected health information to authorized federal officials conducting national security and intelligence activities, including the provision of protective services to the President or others legally authorized.

- **Workers' Compensation:** We may disclose your protected health information as authorized to comply with workers' compensation laws and other similar legally established programs.

- **Inmates:** We may use or disclose your protected health information if you are an inmate of a correctional facility and your physician created or received your protected health information in the course of providing care to you.

- **Required Uses and Disclosures:** Under the law, we must make disclosures to you when required by the Secretary of the U.S. Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500 et. seq.

2. YOUR RIGHTS

You have the following rights regarding medical information we maintain about you:

- **Right to Inspect and Copy.** You have the right to inspect and copy medical information that may be used to make decisions about your care. Usually, this includes medical and billing records but does not include psychotherapy notes.

  To inspect and copy your medical information, you must submit your request in writing to the Department of Medical Assistance Services HIPAA Privacy and Security Officer at the address at the front of this handbook. If you request a copy of information, we may charge a fee for the cost of copying, mailing, or other supplies associated with your request.
  We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to medical information, you may request the denial be reviewed. For more information, call (804) 786-4231.

- **Right to Amend.** If you feel that medical information about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment as long as the information is kept by or for DMAS. To request an amendment, your request must be made in writing and submitted to the Department of Medical Assistance Services HIPAA Privacy and Security Officer at the address at the front of this handbook. In addition, you must provide a reason which supports your request. We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

  - Was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
  - Is not part of the medical information kept by or for DMAS;
  - Is not part of the information which you would be permitted to inspect and copy; or
  - Is accurate and complete.

- **Right to an Accounting of Disclosures.** You have the right to request an "accounting of disclosures." This is a list of the medical information disclosures we made about you. To request this list, you must submit your request in writing to the Department of Medical Assistance Services HIPAA Privacy and Security Officer at the address at the front of this handbook. Your request must state a time period for the disclosures, which may not be longer than six (6) years and may not include dates before April 14, 2003. Your request should indicate in what form you want the list (for example, on paper, electronically).

- **Right to Request Restrictions.** You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment, or health care operations. You also have the right to request a limit on the medical information we disclose about you to someone who is involved in your care

or the payment for your care, like a family member or friend. For example, you can ask that we not use or disclose information about surgery you had.

We are not required to agree to your request. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment.

To request restrictions, you must make your request in writing to the Department of Medical Assistance Services HIPAA Privacy and Security Officer at the address at the front of this handbook. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure, or both; and (3) to whom you want the limits to apply(for example, disclosures to your spouse).

- **Right to Request Confidential Communications.** You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail.

  To request confidential communications, you must make your request in writing to the Department of Medical Assistance Services HIPAA Privacy and Security Officer at the address at the front of this handbook. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

- **Right to a Paper Copy of Privacy Notice.** You have the right to a paper copy of this privacy notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice.

  You may obtain a copy of this notice at our website, www.dmas.virginia.gov.
  To obtain a paper copy of this notice, call (804) 786-4231 during regular working hours.

3. COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with DMAS or with the Secretary of the U.S. Department of Health and Human Services. To file a complaint with DMAS, you may contact our Privacy Contact, DMAS Office of Privacy & Security at (804) 225-2860 for further information about the complaint process.

You will not be penalized for filing a complaint.

4. OTHER USES OF MEDICAL INFORMATION

Other uses and disclosures of medical information not covered by this notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose medical information about you for the reasons covered by your written

authorization. Understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care we provided to you.

This notice was published and became effective on June 27, 2002.

GLOSSARY OF TERMS

Authorized Representative — A person who is authorized in writing to conduct the personal or financial affairs for an individual.

Caseworker — Eligibility worker at the local Department of Social Services who reviews your case to determine if you are eligible for Medicaid. This is the person you would contact regarding changes, such as your address or income, or problems, such as not receiving your Medicaid card.

DMAS — Department of Medical Assistance Services, the agency that administers the Medicaid program in Virginia.

DSS — Department of Social Services, the agency responsible for determining eligibility for medical assistance and the provision of related social services. This includes the local Departments of Social Services.

EPSDT — Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program is a program of preventive health care and well child examinations with appropriate tests and immunizations for children and teens from birth up to age 21. Medically necessary services, which are required to correct or ameliorate defects and physical or mental illnesses that are discovered during a screening examination, may be covered as a part of the EPSDT program even if they are not covered under the State's Medicaid benefit plan.

FAMIS Plus — An assistance program that helps pay for medical care for children under age 19 whose family income is within 133% of the Federal Poverty Limit for the family size.

Medicaid — An assistance program that helps pay for medical care for certain individuals and families with low incomes and resources.

Primary Care Provider (PCP) — The doctor or clinic that provides most of your health care needs, gives you referrals to other health care providers when needed, and monitors your health. A PCP may be an internist, a pediatrician (children's doctor), OB/GYN (women's doctor), or certain clinics and health departments.

Resources

Resources include: money on hand, in the bank, and in a safe deposit box; stocks, bonds, certificates of deposit, trusts, child support payments, pre-paid burial plans; cars, boats, life insurance policies, and real property.